Eligibility Change Form – 2018

Group Name: _Commonwealth of Kentucky # 20108_ **KY Company Name** _____

Enrollee Name: _____ **SS#** _____-_____-_____
OR Payroll ID _____

1) Enrollee Changes:
Name (enrollee): From: _____

To: _____

Address To: _____

City: _____ State _____ Zip _____

Telephone To: ( ) _____

Dependents Changes:
Add:

Name_____ Birth Date ___/___/___ Male ____ Female _____

Name_____ Birth Date ___/___/___ Male ____ Female _____

Name_____ Birth Date ___/___/___ Male ____ Female _____

Delete:

Name_____ Birth Date ___/___/___ Male ____ Female _____

Name_____ Birth Date ___/___/___ Male ____ Female _____

Name_____ Birth Date ___/___/___ Male ____ Female _____

2) Terminate Coverage (Reason) _____

_____ Date of Termination ____/_1_/____

3) Reinstate Coverage (Reason) _____

_____ Effective Date of Reinstatement ___/_1_/___

4.) Plan Change (available after one year):
DENTAL

From:
- ☐ Employee Bronze
- ☐ Employee Gold

To:
- ☐ Employee Bronze
- ☐ Employee Gold
- ☐ Retiree (see Agency Administrator)

Plan Change (available after one year):
VISION

From:
- ☐ Employee

To:
- ☐ Retiree (see Agency Administrator)

New Premium Deduction:
$_____
(Note: Check payroll deduction for correct deductions amount.)

5) Other (Explain)_____

Effective Date of Change: ___/_1_/___**(DATE MUST BE THE 1ST OF THE TERMINATION MONTH)**

Signature _____
Authorized party (enrollee, administrator, etc.)

Fax Changes to: Krol Insurance Agency 502-875-3615

CWCH2013